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A Case of Laryngeal Growth.

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A CASE OF LARYNGEAL GROWTH.

Operations for the removal of laryngeal growth are of such common occurrence and the subject has been so thoroughly treated by laryngologists, that there would seem nothing new or interesting upon this subject to be added. The case I am about to report, while not individual, is one of uncommon nature and presents certain points of interest.

On November 4, 1886, Mr. W. E. S. was referred to me by Dr. Z. T. Sowers, with the following history: The patient had been unusually free from sickness of any character previous to the development of the present affection. His family history is excellent, no hereditary tendencies being found upon either paternal or maternal side. When about the age of 11 he began to sing as chorister boy, filling a soprano part, in the church at his native home, near Sheffield, and continued to serve in that capacity until his 16th year, when he was obliged to desist on account of the period of mutation having set in. Later I shall try to show the influence of this singing upon the production of this growth. At about his 20th year, his voice had rounded into a deep bass, marred, however, with a very slight touch of hoarseness. Two years later this hoarseness had increased to such a degree that he was obliged to give up singing. This change in his voice became greater and a new symptom developed, which the patient described as a "catch in the voice." About this time our patient came to America.

Shortly after his arrival in America he noticed that he breathed with greater difficulty, especially at night, which continued to increase until the re-

moval of the growth. Dysphagia was present to a slight extent.

Present Condition.—The first point that attracted my attention was the character of his voice, and his apparent difficulty of breathing. This voice was not one of marked hoarseness, as is usually found in cases of laryngeal growth, but rather resembling the hoarseness of laryngeal blennorrhea, produced by three factors, viz.: the excessive amount of mucus which adheres to the chords not only preventing their apposition but also producing secondary tones, paresis, and infiltration into and thickening of the substance of the chords. While the patient was conversing with this slight hoarseness there was a sudden arrest of the voice, while the lips moved and the patient made violent attempts to speak—resembling very much the efforts seen in a stutterer—the words remaining unpronounced. After a few ineffectual efforts, a toss of the head, followed by a deep inspiration—attended with a decided stridor—he regained his voice. He continued to converse in this slightly hoarse voice until again interrupted by another complete cessation of the voice. These attacks, if I may so call them, were at times—when the patient persisted in his efforts to speak—accompanied by marked dyspnœa. Dyspnœa was another symptom from which the patient has suffered considerably, and it was this one alarming symptom which caused him to seek medical advice. He had no special hunger for air while in repose, or taking moderate exercise, but should he exert himself, as in walking fast, ascending heights and steps, or bicycling, the want of air became very pronounced.

Dyspnœa was very marked at night, and not infrequently attended with severe asthmatic seizures. The patient states, "For the last six months I have not had a pleasant night's rest. I am constantly aroused from my sleep by feelings of suffocation and when asleep toss from one side of the bed to the

other." These asthmatic paroxysms occurred almost always while the patient was on his back, and very frequently while his face was covered with the sheet —a habit of which he was guilty while asleep.

Objective Examination.—The tongue was normal, as well as the mucous membranes lining the surface of the buccal cavity. Tonsils, uvula and palatine arches presented no deviation from the normal condition. Pharynx congested, and presenting here and there small shreds of adherent mucus. Naso-pharynx quite roomy and showing slight glandular hypertrophy. On the first introduction of the laryngeal mirror, and the patient having been told to intone *a*, there was apparently nothing foreign discernible. The cords showed only a slight want of opposition, a fact readily explained by the large clumps of mucus interposed between and firmly adherent to their free edges. The whole of the larynx, epiglottis, ary-epiglottidean folds, false cords and arytenoids, presented quite a marked appearance of congestion. The vocal cords themselves were infiltrated, of a dirty, pinkish-yellow color, passing into a bright red at their free edges—covered here and there with small masses of adherent mucus. I told the patient to clear his voice, and introduced the mirror a second time—with no better result than before. I then caused the patient to make a deep inspiration, in order to get a good view of the sub-cordal portion of the larynx, but could discover nothing, except that this portion of the larynx was excessively congested.

The patient, being now quite restless, after allowing him to rest a few moments, I requested him to make a deep inspiration, to be followed by a forced expiration, at the end of which he was to intonate *a*, sharply. Just before he finished his expiration, I quickly introduced my mirror and beheld the following: a large, bright red body measuring one centimetre in length and six millimetres in breadth,

was imprisoned between the vocal cords, extending from the anterior commissure to the processus vocales, posteriorly and overlapping to some extent the vocal cords. This growth presented two lateral and one inferior lobe, the latter being imprisoned between the cords, the former spreading over the cords on each side, thus acting like a valve, and explaining the pronounced dyspnœa which occurred during the aphonic stages. It can be readily seen how, the patient persisting in his efforts to phonate— the cords contracting upon the inferior lobe, the lateral lobes spreading out over the surface of the cords—the growth interfered with respiration until the desire for air became so great as to cause him to relax his efforts, the growth being drawn into the sub-corded portion of the larynx in the manner already described. The patient being asked to inspire, which he accomplished after several efforts, the cords separated and the growth passed into the sub-cordal portion of the larynx. It is well to observe here that the cords, even during a deep inspiration, did not expand fully—the right cord, to which the growth was attached, never passing beyond the cadaveric position, the left cord making only a slightly greater excursion than its fellow. After several more examinations, I came to the conclusion that the tumor was attached to the under surface and inner edge of the right vocal cord within a line of the anterior commissure. After putting my patient through a thorough course of training, which the use of that valued agent, cocaine, does not render unnecessary, of four days' duration, and being satisfied that he would follow all directions, I decided to operate on the fifth day.

On Monday, November 8, in the presence of Dr. Sowers, after thoroughly applying a 20 per cent. solution of cocaine to the larynx, I removed the growth with Schrœther's modification of Türck's pincette. On the first attempt at introduction of the instrument, and as I was passing back of the epiglottis, he

made an effort at deglutition which compelled me to remove the instrument and the mirror. In a few moments I quieted him and again introduced my instrument, passing it well downward and forward to the anterior commissure to the point of attachment, and after firmly grasping the growth, evulsed it. Again examining the larynx, to see if all the growth had been evulsed, I found it so filled with blood as to obscure entirely the supposed site of attachment. On examining the patient the following day, I observed a small portion of the pedicle, about two millimetres in diameter, projecting from beneath the free edge of the right vocal cord. This was removed without difficulty and brought with it a small portion of mucous membrane. My patient had now nearly a clear voice. For several weeks thereafter, I made local applications of nitrate of silver for the purpose of relieving the co-existing laryngitis. After this course of treatment, I discharged my patient, completely relieved, with every function of the larynx normal, and he so remains at the present writing. I am sorry that I did not have a careful microscopical examination of the growth made—which I would have done had I intended reporting the case. From macroscopical appearances it bore all the characteristics of a fibroma.

There are several points of interest in this case, the most important of which, and the one to which I first call your attention, is that these forms of growth, especially when quite small, frequently lead to errors in diagnosis, even if one be an adept in laryngeal examinations. That they are not mere fancies, but that errors do occur may be illustrated by my own experience as well as that of others who have had vast experience in laryngological work. By citing a hypothetical case, which will not be overdrawn, I may better illustrate this point.

A patient comes with a history of slight hoarseness of some years duration, possibly slight dyspnœa, his

patience exhausted by a long course of ineffectual treatment by the general practitioner, and, I might add, in a doubting frame of mind. The patient undergoes his first laryngeal examination which on account of his nervous condition is attended with a little difficulty. A hasty view is obtained and the larynx is seen to be in a state of chronic inflammation, the vocal cords are infiltrated, presenting here and there little shreds of mucus running from one cord to the other, possibly showing a little insufficiency. The sub-cordal portion is seen to be in a much congested condition, and the growth on account of its small size and situation, being of the same bright red color as the sub-cordal mucous membrane, and lying well hidden beneath the anterior commissure and the cord to which it is attached, fails of detection. Rapidly running over in mind the conditions which could give rise to such symptoms, we eliminate all except chronic laryngitis, with slight paresis, the evidences of which are present, and imparting this information to our patient—a little guardedly, probably—and with the advice to call on the morrow, dismiss him. The same information he has probably received before, hence he leaves never to return. A few days later a neighboring specialist narrates to you an interesting case of laryngeal growth, and in it you recognize your case of a few days ago. Chagrin and vexation would not have been yours, had you been a little more careful and thorough in your examination. As I have previously stated, such cases are not fanciful, for I have seen three such mistakes committed, and in one of the cases was the error committed by quite a distinguished laryngologist. Prof. Schrœther once made the remark while speaking of a case of this nature, that no laryngologist should allow such a patient, one presenting the symptoms enumerated above, to leave his consultation room with a diagnosis of chronic laryngitis only, without adopting all ma-

nœuvres necessary to explain such a condition, of which the forced expiration after a deep inspiration, with the rapidly following intonation of *a*, is important in proving the existence or non-existence of a growth attached to the under surface of the cords. Even in the present case, the growth being quite large, at the second examination after the greatest care and effort I could not bring the growth to view and almost doubted my having seen it on the previous day.

On the fourth day—the patient now submitting freely to laryngeal examination—one of my professional friends who is quite an adept in the use of the laryngeal mirror, called, and, after I explained to him the nature of the growth, he procceeded to examine the patient. After introducing his mirror several times I could see by the expression of his face that he was beginning to doubt my diagnosis. I subsequently proved to him the existence of the growth, with evident satisfaction, as the incredulous expression gradually gave way to one of credulity. It is useless for one to assert that he would not make such an error, for even with these facts fresh in his memory, he may on the morrow be guilty of committing such an error. It is only by constantly calling attention to the possible errors in diagnosis that we are able to avoid them.

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